IDAHO DEPARTMENT OF HEALTH AND WELFARE
DIVISION OF HEALTH
450 WEST STATE STREET – 4TH FLOOR
P.O. BOX 83720
BOISE, IDAHO 83720-0036

APPLICATION FOR REGISTRATION AS A FREE MEDICAL CLINIC

Instructions: Please complete this entire application and submit it to the above address with a check in the amount of $50.00 made payable to the Bureau of Health Planning and Resource Development.

The undersigned hereby makes application for registration as a free medical clinic, subject to the provisions of the Idaho State Code, and to the rules, regulations and standards adopted thereunder by the Department of Health and Welfare.

A. Facility Name:_____

Sponsoring Organization (if applicable):_____

Organizational Officials (if applicable):_____

B. Address:_____

_____, Idaho_____
City Zip County

Telephone Number:_____ Fax:_____

E-mail Address:_____

I certify that this community-based program provides primary medical care without charge to individuals unable to pay and that the information herein submitted is true, complete and correct, to the best of my knowledge and belief.

Signature:_____

Title:_____

Date:_____

☐ Approved

☐ Disapproved (reason) _____
_____

_____ _____
State Registrar Date